

3742

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03730

Reg. Dist.

No. 194

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Howard	MARYLAND	STATE Maryland	COUNTY Howard
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Glenelg	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Glenelg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
CHRISTINE CAROL BROWN		4-7-55 19	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
Female	White	Single	12-8-54
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		9b. KIND OF BUSINESS OR INDUSTRY:	
10. BIRTHPLACE (State or foreign country):		11. CITIZEN OF WHAT COUNTRY?	
Fort Meade Hos.			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Morris Bladen Brown		Dollie Virginia Riely	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
No		None	
17. INFORMANT & ADDRESS:			
Mrs. Dollie Brown, Glenelg, Md			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) OTITIS MEDIA - BILATERAL			
Antecedent cause(s) (b) and INTERSTITIAL PNEUMONIA			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .			
SIGNATURE George E. Bungtorf		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/7/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	4-11-55	LINETHICUM CHAPEL	CLARKSVILLE, Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-11-55	Marie A. Whitaker	F. C. HIGGINBOTHAM	ELLICOTT CITY Md

20V4162415

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05668

Reg. Dist. No. 198

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lisbon</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>	
TOWN <u>Lisbon</u>		TOWN <u>Mount Airy</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>-</u>		STREET ADDRESS (If rural, give location) <u>Buffalo Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Ella</u> (Middle) <u>Virginia</u> (Last) <u>Clary</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>30</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12-17-1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Teacher - piano</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>	
13. FATHER'S NAME <u>Woodson Clary</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Van Sant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Monroe Clary, Lisbon</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Massive Hemorrhage</u>		<u>3 hours</u>
Antecedent cause(s) (b) <u>Carcinoma of Cervix with metastases</u>		<u>About 1 year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>Jan 6 + 20, 1955</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Cervix - metastases pelvis + Abdomen</u>		
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December 1954, to April, 1955, that I last saw the deceased alive on April 1, 1955, and that death occurred at 8 P. m., from the causes and on the date stated above.

SIGNATURE W.B. Culwell M.D. ADDRESS mt. Airy, md DATE SIGNED April 30, 1955

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>5-3-1955</u>	NAME OF CEMETERY OR CREMATOR <u>Prospect</u>	LOCATION (City, town, or county) (State) <u>Frederick Co. md.</u>
DATE REC'D BY LOCAL REG. <u>5-2-1955</u>	REGISTRAR'S SIGNATURE <u>C Pearl Murches</u>	24. FUNERAL DIRECTOR <u>G.M. Waltz</u>	ADDRESS <u>Winfield, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1900

BUREAU OF S.

MARYLAND

STATE DEPARTMENT OF HEALTH

3743

CERTIFICATE OF DEATH

Reg. Dist. No. 19-2

1. PLACE OF DEATH- COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>HOWARD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WOODSTOCK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WOODSTOCK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GROOMES LANE.</u>		STREET ADDRESS (If rural, give location) <u>GROOMES LANE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>NONA</u> (Middle) <u>ELIZADETH</u> (Last) <u>CRUM</u>	4. DATE OF DEATH <u>APR. 26</u> 19 <u>55</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11-16-1882</u>
9. AGE last birthday <u>72</u> yrs.		10. If under 1 year Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>LAUREL MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE BAER</u>		14. MOTHER'S MAIDEN NAME <u>UNK -</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT AND ADDRESS <u>FRANK CRUM WOODSTOCK, MD.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause (a) <u>LEFT CARDIAC FAILURE (PULMONARY EDEMA)</u>				12 Hrs	
Antecedent cause(s) (b) <u>CEREBROVASCULAR ACCIDENT</u>				2 Mo.	
(260X) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>				Yrs.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>DIABETIS MELLITUS</u>				14 Yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec. 15, 1954, to Apr. 26, 1955, that I last saw the deceased alive on Apr. 26, 1955, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

SIGNATURE <u>A. H. Hight</u> (Degree or title) <u>MD.</u> ADDRESS <u>RANDALLSTOWN MD.</u> DATE SIGNED <u>MD.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>4-26-55</u> NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u> LOCATION (City, town, or county) <u>FREDERICK MD.</u>
DATE REC'D BY LOCAL REG. <u>April 27, 1955</u> REGISTRAR'S SIGNATURE <u>Alice H. Hight</u>	24. FUNERAL DIRECTOR <u>Arthur H. Hight</u> ADDRESS <u>Hydrusville, Md.</u>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 3 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Howard</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Howard</i>	
CITY (If outside corporate limits, write RURAL or give nearest town) <i>near Savage</i>		LENGTH OF STAY (in this place) <i>7 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>near Savage</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Mission Rd.</i>				STREET ADDRESS (If rural, give location) <i>Mission Rd. Joseph (P.O.)</i>			
3. NAME OF DECEASED: (Type or Print) <i>William Edward Dean</i>				4. DATE OF DEATH: (Month) <i>April</i> (Day) <i>8th</i> (Year) <i>1955</i>			
5. SEX: <i>M</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH: <i>Jan 15 - 1867</i>	
9. AGE last birthday: <i>88</i> yrs. Months Days Hours Min.				10. USUAL OCCUPATION. Give kind of work done during most of working life. <i>Retired</i>			
11. BIRTHPLACE (State or foreign country): <i>Laurel Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME: <i>Lawrence Dean</i>				14. MOTHER'S MAIDEN NAME: <i>Susan Ann Carter</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>				16. SOCIAL SECURITY NO.: <i>None</i>			
17. INFORMANT & ADDRESS: <i>William Edward Dean, Jr.</i>				Interval Between Onset And Death: <i>24 hrs.</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <i>Ac. Congestive Cardiac Failure</i>							
Antecedent causes (s) (b) <i>Chr. Myocarditis</i>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 1949</i> , to <i>April 8th 1955</i> , that I last saw the deceased alive on <i>April 8, 1955</i> , and that death occurred at <i>9:30 P</i> , from the causes and on the date stated above.							
SIGNATURE <i>Frank Shipley, M.D.</i>				DATE SIGNED <i>4/9/55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>April 11-1955</i>		<i>St. John's</i>		<i>Laurel Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>4/9/55</i>		REGISTRAR'S SIGNATURE <i>Frank Shipley</i>		24. FUNERAL DIRECTOR <i>Reverend Ronaldson Laurel Md.</i>		ADDRESS	

RECEIVED
APR 13 1955
BUREAU V. S.

3745

CERTIFICATE OF DEATH

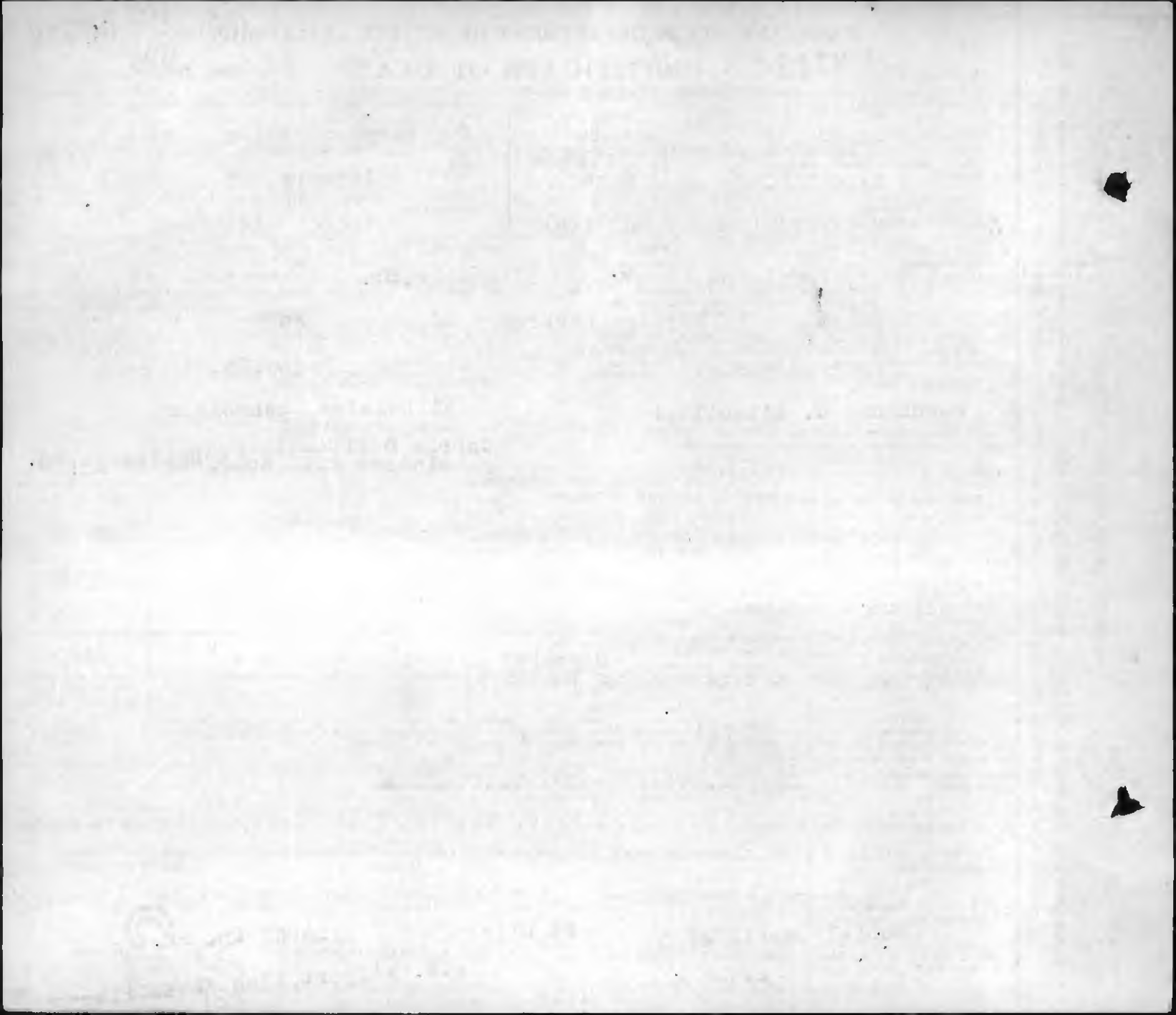
Reg. Dist. No.

171

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Ellicott City</u>		5 mos		OR TOWN <u>Baltimore, Md.</u> 03X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Taylor Manor Hospital		STREET ADDRESS (If rural give location) Windsor Mill Road			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Ferdinand C. Eitemiller Sr.				April 24 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	February 28, 1886	69 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Retired farmer		farming		Woodlawn, Balto, Co. Md		U.S.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Ferdinand C. Eitemiller				Wilhelmina Schroader			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
(If Yes, give war or dates of service)				Carrie O Eitemiller Windsor Mill Road, Baltimore, Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X IMMEDIATE CAUSE			(A) Bronchial pneumonia				2 weeks
ANTECEDENT CAUSE (S)			(B) Cerebral Thrombosis				4 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDIION CAUSING DEATH.							5 years
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
2. I hereby certify that I attended the deceased from Nov. 14 19 55 to April 24 19 55 that I last saw the deceased alive on April 24, 19 55 and that death occurred at 6 P.M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
J. J. Taylor		M. D. Taylor Manor Hospital		April 24, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		April 27, 55		Mt Olive		Woodlawn, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
4-25-55		F.W. Hargrave		F.B. Wippert, 1300 Eutaw Place			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3746

03735

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 191

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Howard	MARYLAND	STATE Maryland	COUNTY Carroll
CITY (If outside corporate limits, write RURAL OR and give nearest town) Ellicott City	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) Mt Airy	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Orchard Route 40 East Bound Lane		STREET ADDRESS (If rural, give location) R F D 2	
3. NAME OF DECEASED: (Type or Print)	(First) TRUMAN	(Middle) ASA	(Last) FRANKLIN
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	4. DATE OF DEATH 4-22-1955 19
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farm	10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner	11. BIRTHPLACE (State or foreign country): Maryland	9. AGE last birthday: 47 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
13. FATHER'S NAME: Wm. Franklin	14. MOTHER'S MAIDEN NAME: Koontz		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.: 219-26-3144	17. INFORMANT & ADDRESS:	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)..... Fracture of Skull DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause, stating underlying cause last (c).....			Instant
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Multiple fractures and abrasions			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg, etc.) INJURY Highway #40	21c. (City or town) Pine Orchard Ellicott City	(County) Howard (State) Md
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 4-22-1955 10.30PM	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Pedestrian struck by tractor-trailer	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE George E. Buntz Ellicott City, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED 4-22-55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF 4-25-55	NAME OF CEMETERY OR CREMATORY Taylorsville	LOCATION (City, town, or county) (State) Taylorsville, Md.
DATE RECD BY LOCAL REG. 4/23/1955	REGISTRAR'S SIGNATURE John B. Loughran	24. FUNERAL DIRECTOR C.V. Waltz, Winfield, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

CHAND A. S.

APR 11

13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 190

3747

03736

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ELKridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>LAWYERS HILL ROAD</u>		STREET ADDRESS <u>32 N. BERNICE AVE.</u>	
3. NAME OF DECEASED (Type or Print) <u>MARGARET MATILDA GERNHART</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>23</u> (Year) <u>1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>12/29/86</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	9. AGE last birthday <u>58</u> yrs.
13. FATHER'S NAME <u>CLIFTON ZIEGLER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET WEEDON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. HELEN LAYNOR LAWYERS HILL RD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
170X Immediate cause (a) <u>Generalized Carcinomatosis</u>		
Antecedent cause(s) (b) <u>CA R. Breast.</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4/12, 1955, to 4/23, 1955, that I last saw the deceased alive on 4/23, 1955, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

SIGNATURE <u>John B. H. Ealy</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>Baltimore, Md.</u>		DATE SIGNED <u>4/23/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE <u>4-26-55</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
DATE REC'D BY LOCAL REG. <u>4/27/55</u>		REGISTRAR'S SIGNATURE <u>(Michael E. Reid)</u>		24. FUNERAL DIRECTOR <u>George L. Schaub</u>		ADDRESS <u>2101 Frederick Ave. BALTO., Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FRANK V. S.

APR 17 1955



3748

03737

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 191

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Howard	MARYLAND	STATE Md.	COUNTY Howard
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Ellicott City		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Ellicott City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 21 Fells Avenue		STREET ADDRESS (If rural, give location) 21 Fells Avenue	
3. NAME OF DECEASED: (First) (Middle) (Last) JEFFERY HAMMOND		4. DATE OF DEATH (Month) (Day) (Year) April 19 19 55	
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH: Feb. 9, 1954
9. AGE last birthday: 1 yr. 3 mos.		10. BIRTHPLACE (State or foreign country): Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Cornelius Hammond		14. MOTHER'S MAIDEN NAME: Beverly Dunn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None	
17. INFORMANT & ADDRESS: Deverly Hammond, Ellicott City, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
491X Immediate cause (a) DUE TO Bronchopneumonia			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? Partial			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		DATE SIGNED	
W. B. E. L. S.		4/20/55	
23. BURIAL, CREMATION, REMOVAL (Specify):		NAME OF CEMETERY OR CREMATORY	
Burial		Fuller Family Cemetery	
DATE REC'D BY LOCAL REG. April 20, 1955		LOCATION (City, town, or county) (State) Howard Co., Md.	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
John B. Loughman		Easton Sons	
P. B. E. L. S.		ADDRESS Ellicott City, Md.	

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

sh

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1955

1955

03738

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3749

CERTIFICATE OF DEATH

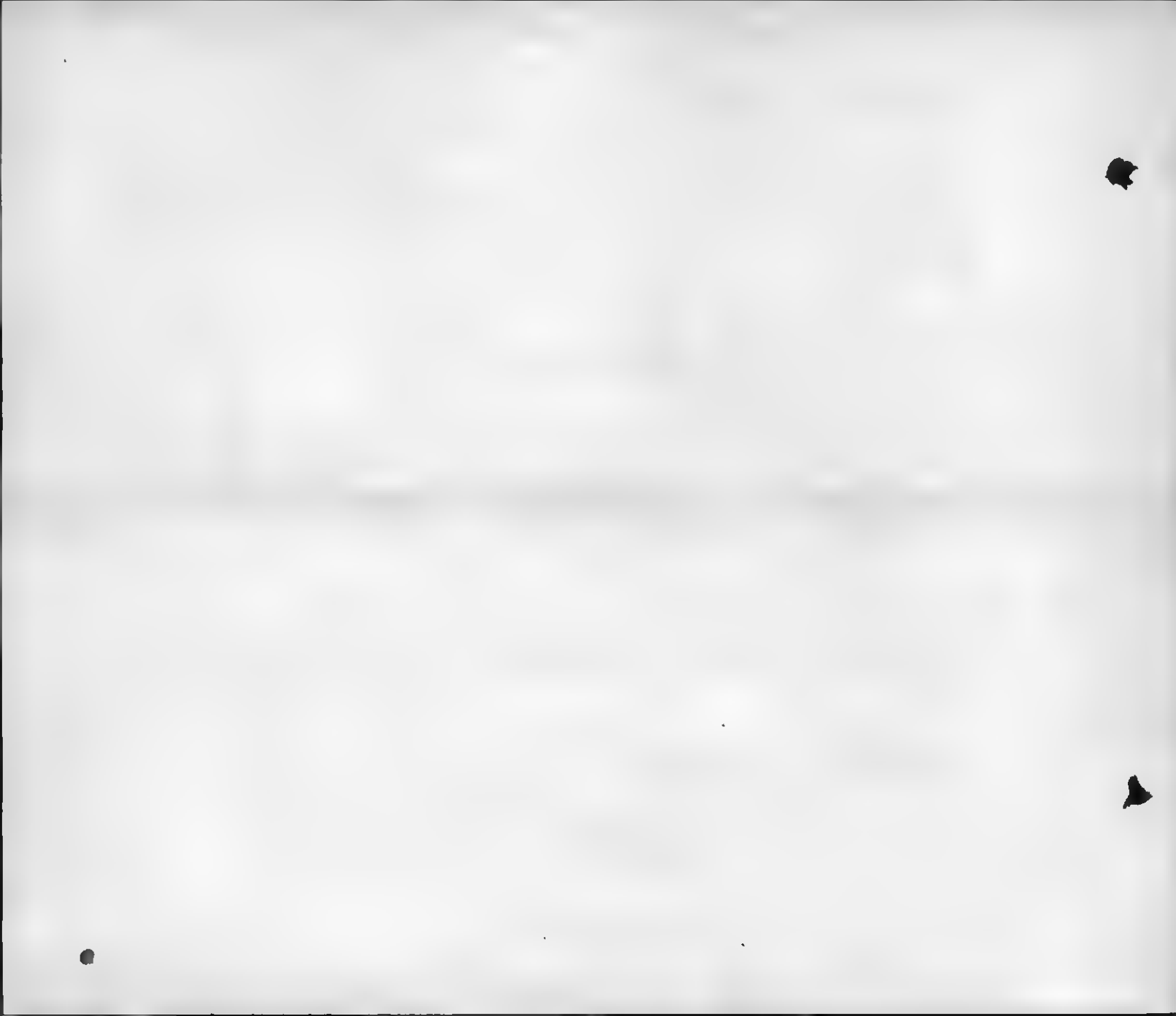
Reg. Dist. No. 191

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Ellicott City</u>		1 day		OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taylor Manor Hospital</u>				STREET ADDRESS (If rural give location) <u>3319 Liberty Heights Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>Jesse Willard Jones</u>				OF DEATH <u>April 22 19 55</u>			
5. SEX. <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widower</u>		8. DATE OF BIRTH: <u>May 10, 1908</u>	
9. AGE last birthday: <u>46</u> yrs.		Months <u>4</u> Days <u>19</u> Hours <u>55</u> Min.		9. AGE last birthday: <u>46</u> yrs.		10. MONTHS <u>4</u> DAYS <u>19</u> HOURS <u>55</u> MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Coal Broker</u>			
11. BIRTHPLACE (State or foreign country): <u>Wilkesbarre, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME: <u>Jesse Willard Jones</u>				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <u>Hospital Record</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
307x IMMEDIATE CAUSE (A) <u>Bronchial pneumonia</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Delerium Tremens</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pathological alcoholic intoxication</u>							
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. WHERE DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21G. HOW DID INJURY OCCUR?			
I hereby certify that I attended the deceased from <u>April 22, 19 55</u> to <u>Apr 22, 19 55</u> that I last saw the deceased alive on <u>Apr. 22</u> , 19 55, and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Taylor</u>				ADDRESS <u>M.D. Taylor Manor Hospital</u>			
DATE SIGNED <u>April 22, 1955</u>				DATE SIGNED <u>April 22, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Apr 24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hanover Greens</u>		LOCATION (City, town, or county) (State) <u>Hanover Township Pa</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 23, 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. GENERAL DIRECTOR ADDRESS <u>4905 York Rd</u>			

MARGIN RESERVED FOR BINDING

A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

03739

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

3750

1. PLACE OF DEATH COUNTY Howard		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ellicott City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fells Ave		STREET ADDRESS (If rural, give location) Fells Ave.	
3. NAME OF DECEASED (Type or Print) THOMAS		4. DATE OF DEATH (Month) (Day) (Year) Apr. 15 1955	
6. SEX Male		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	
8. COLOR OR RACE Colored		8. DATE OF BIRTH About 1875	
9. AGE last birthday ? 80 yrs.		10. AGE last birthday If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Basil Matthews		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Carrie Matthews, Ellicott City, Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 days
(a) 422.1 Cerebral Hemorrhage		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause including the underlying cause last		
(c) Arteriosclerotic Cardio-Vascular Disease		3 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **2/6/52**, 19**52**, to **4/15/55**, 19**55**, that I last saw the deceased alive on **4/14/55**, 19**55**, and that death occurred at **1 P.M.**, from the causes and on the date stated above.

SIGNATURE William F. Lanning M.D.		ADDRESS Ellicott City, Md.		DATE SIGNED 4/15/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 4-18-55		NAME OF CEMETERY OR CREMATORY Locust Chapel	
LOCATION (City, town, or county) (State) Simpsonville, Md		24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		ADDRESS	
DATE REC'D BY LOCAL REG. April 18, 1955		REGISTRAR'S SIGNATURE John B. Loughran		Pm. B. E. L.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

DOMINICAN A. S.

A R

1000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

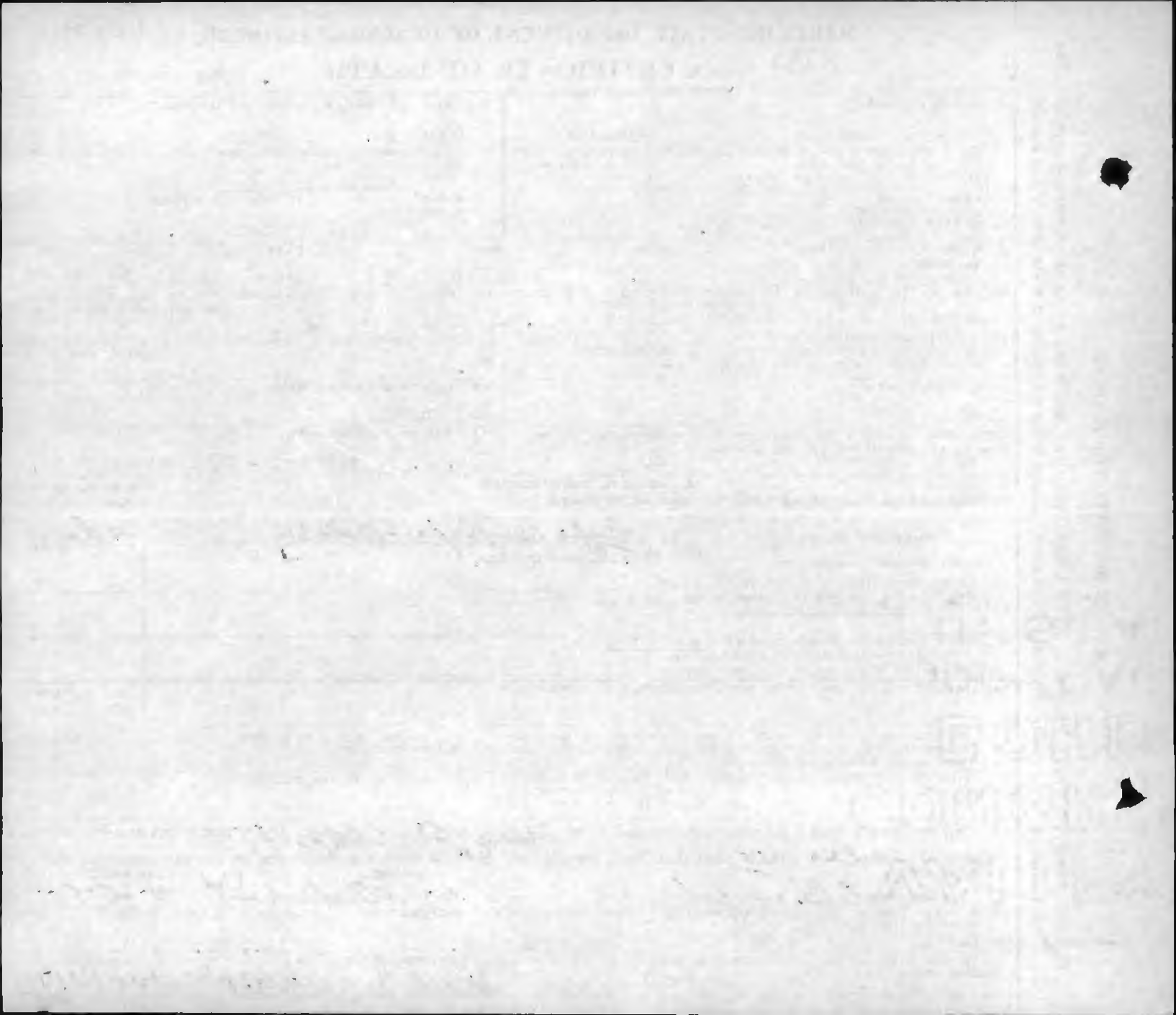
03740

3751

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3701-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Church Rd.</u>		STREET ADDRESS (If rural give location) <u>1541 Northwick Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>ELSIE C. RODEKURT</u>		<u>April 23 19 55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Oct. 14, 1881</u>
9. AGE last birthday: <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>never worked</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	11. BIRTHPLACE (State or foreign country): <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: <u>Not Known</u>	
14. MOTHER'S MAIDEN NAME: <u>Not Known</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Mr. C. W. Rodekurt - 1541 Northwick Rd.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE		4 days	
ANTECEDENT CAUSE (S):		(A) <u>Right hemiplegia - probably</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>thrombosis.</u>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar. 1953</u> , to <u>April 23 1955</u> that I last saw the deceased alive on <u>April 22, 1955</u> , and that death occurred at <u>8 A M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Darbit B. Taylor</u>		DATE SIGNED <u>4-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/26/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-1-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3752 CERTIFICATE OF DEATH

03741

Reg. Dist. No. 191

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ellicott City</u>	LENGTH OF STAY (In this place) <u>61 Yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellicott City, Md.</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Columbia Pike</u>		STREET ADDRESS (If rural give location) <u>Columbia Pike</u>	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ETHEL M. WOSCH</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>April 1, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Sept. 8, 1880</u>
9. AGE last birthday: <u>74</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Charles W. Betts</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah A. Holden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. C. H. Cook Columbia Pike Ellicott City, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
260X IMMEDIATE CAUSE		
(A) <u>acute Pulmonary Edema</u>		
ANTECEDENT CAUSE (S)		
(B) <u>Coronary artery disease</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) <u>Shuntles Mellitus</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
-------------------------	----------------------------------	---

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from Mar., 1955, to April 1, 1955, that I last saw the deceased alive on April 1, 1955, and that death occurred at 8:30 P. M. from the causes and on the date stated above.

SIGNATURE <u>Robert B. Ligher</u>	M.D. <u>Ellicott City, Md.</u>	DATE SIGNED <u>4-3-55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>4/4/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>
		LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>

DATE REC'D BY LOCAL REGISTRAR <u>April 3, 1955</u>	REGISTRAR'S SIGNATURE <u>John B. Loughran</u>	24. FUNERAL DIRECTOR <u>Easton Sons</u>	ADDRESS <u>Catonsville, Md.</u>
--	---	---	---------------------------------

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 7 1955

BUREAU V. S.